FBMC

Fringe Benefits Management Company

COMMONWEALTH OF VIRGINIA
January 1 - December 31, 2001

FLEXIBLE REIMBURSEMENT ACCOUNT ELECTION FORM

To enroll in or make changes to your Flexible Reimbursement Accounts (FRAs), you may contact your agency's Benefits Administrator, visit the DHRM web site at www.dhrm.state.va.us/hbenefit.htm, or complete this paper election form.

To start, continue or change your account, place the election amount for the plan year in Box 1. Enter the number of paychecks and revised deduction per paycheck for the remainder of the plan year in Boxes 2 and 3 of the appropriate account.

To discontinue participation, place a zero in Box 3 of the applicable account.

Press hard with ballpoint pen.

Social Security #	Agency Number

Name (Please Print) Last	First	MI	E-mail Address

Home Address	City	State	Zip

Daytime Phone	Home Phone	Date of Hire	Date of Birth	No. Pay Periods	Annual Salary
( )	( )				

ENROLLMENT STATUS ☐ CHANGE IN STATUS* ☐ NEW HIRE ☐ ANNUAL ELECTION PERIOD — Effective Date

*Indicate the Change In Status event you have experienced by checking the appropriate box on the back of this form.

Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
Complete the worksheets provided in your Flexible Benefits Sourcebook before deciding on the amount.
If you have questions, consult your Flexible Benefits Sourcebook, Benefits Administrator or call FBMC Customer Service at 1-800-342-8017.

In Box #1 indicate the dollar amount you elect to contribute for the plan year.
In Box #2 indicate the number of regular payroll checks you expect to receive during the plan year. (If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year, based on your effective date.)
In Box #3 indicate the deduction amount per paycheck. (Note: if Box #2 times Box #3 does not equal box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding). For changes during the plan year, this amount will indicate the revised deduction.

MEDICAL EXPENSE FLEXIBLE REIMBURSEMENT ACCOUNT

For eligible medical expenses incurred by you, your spouse and eligible dependents.
[Minimum is $480 per year; Maximum allowable contribution is $5,000)

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected ÷ _____

Box #3
Deduction per regular paycheck = _____

DEPENDENT CARE FLEXIBLE REIMBURSEMENT ACCOUNT

TAX FILING STATUS [PLEASE CHECK ONE]: Minimum is $480 per year

☐ Married, filing separately [maximum - $2,500]
☐ Married, filing jointly [maximum - $5,000]
☐ Single, head of household [maximum - $5,000]

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected ÷ _____

Box #3
Deduction per regular paycheck = _____

IMPORTANT. I UNDERSTAND THAT:

- I hereby authorize my employer to reduce my gross salary before taxes are calculated by the total amount of annual salary reduction indicated above.
- Any amount remaining in any FRA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- The funds in one FRA cannot be used to reimburse expenses covered by another FRA.
- Expenses for which I am reimbursed cannot be deducted on my income tax return.
- The funds in any FRA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- The monthly administrative fee will be deducted from my paycheck.
- The amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved Change In Status with the Benefits Administrator within 31 days of the event.
- And agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FRA or my failure to sign or accurately complete this election form.

Employee Signature	Date Signed

Benefits Administrator Signature	Date Signed

DO NOT WRITE BELOW THIS LINE — FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES

SUBMIT YOUR COMPLETED FORM TO YOUR BENEFITS ADMINISTRATOR IMMEDIATELY.

Changes In Status

You may change a benefit election upon the occurrence of a valid change in status event but **only** if your change is made **on account of, and corresponds with**, a change in status that affects your own, your spouse's or your dependent's *coverage eligibility*. Assuming that these general consistency requirements are satisfied, if the change in status event affects eligibility for a particular coverage, a corresponding change can be made to the same type of coverage.

You must complete and submit this form within 31 days of the event. The Benefits Administrator for your agency will determine if your Change In Status meets IRS regulations. If your change results from a valid Change In Status, your existing benefits will be stopped or modified (as appropriate) at the first of the month following the event (exception: For birth/adoption, Premium Conversion will be effective the first of the month of the birth or adoption).

Please check below which Change in Status event you have experienced below:

- ❑ change in legal marital status, including marriage, death of spouse or divorce
- ❑ change in the coverage/cost of my daycare provider
- ❑ change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent. *Existing* dependents can also be added whenever a dependent gains eligibility as a result of a valid Change In Status event
- ❑ change in employment status of employee, your spouse or your dependent, including: termination or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; change in work schedule, including an increase or decrease in the number of hours of employment; a switch between full-time and part-time status, and a change in worksite
- ❑ an event that causes an employee's dependent to satisfy or cease to satisfy the requirements for eligibility coverage due to attainment of age, student status or any similar circumstances as provided under the accident or health plan under which the employee receives coverage, and
- ❑ a change in the place of residence of the employee, spouse or dependent
- ❑ other.